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SATURDAY, OCTOBER 17, 1874.

ORIGINAL LECTURES.

CLINICAL LECTURE
ON THE DIAGNOSIS OF THE DISEASES OF WOMEN.

BY F. H. GETCHELL, M.D.,

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GENTLEMEN,—When Demosthenes was asked what was the first part of oratory, he answered, delivery; and the second—delivery; and the third—delivery; and I think we may safely say that the first object to be obtained by the study of gynæcology is diagnosis; and the second, diagnosis; and the third, diagnosis. To be sure, we are not to stop here; but after a correct diagnosis has been made the case is plain, and without it there will be no success either in prognosis or treatment. The diagnosis of uterine disease is not or ought not to be very difficult, and still one who devotes much time and attention to the study of the diseases of females is constantly meeting with cases where an incorrect diagnosis or no diagnosis at all has been made.

Now, why is this? The modes of examination are numerous, and the directions how to proceed are plainly given in the text-books. The reason is not that the means of diagnosis have failed to clear away the obscurities of the case, but that the practitioner has failed to make use of them, and after the most superficial examination, from which he has no right to expect to learn anything, he concludes either that he knows all about it, or that he doesn't know anything about it, as the case may be; and the result, so far as the recovery of the patient is concerned, is the same either way. My experience coincides with that of Dr. Thomas, who says, "I have been struck by the fact that the source of difficulty is almost always the same. The failure of diagnosis has not been due to their having incorrect conclusions from diagnostic means, but to their not having brought these means fully into action, and properly applied them to the solution of the case in hand." If we are to obtain information that will be of any value to us in the treatment of these cases, our examination must be systematic and thorough. It is time that the asking a few irrelevant questions, the hurried introduction of a speculum, and the whitening the os with nitrate of silver, were done away with. The art of observing, which has been called the alphabet of diagnosis, while it is within the reach of those resolved on its attainment, and is sure to be acquired by those who systematically and patiently cultivate the habit of close observation, is by no means so easy to acquire as you may suppose. You must remember that it is not the amount of disease that passes under the physician's observation that gives him knowledge; one man will learn more from one case than another will from a hundred, by close observation. I mean that love of investigation that allows nothing, however insignificant, to escape it; the minutest details are observed and recorded; and here let me say to you that perhaps there is nothing that retards the advancement of young physicians more than contempt for minutiæ. They are so apt to forget that those who achieve the grandest results are the men who allow nothing to escape their notice. It is told of Wellington that on the publication of his "Dispatches," one of his friends said to him, on reading the records of his Indian campaigns, "It seems to me, duke, that your chief business in India was to procure rice and bullocks." "And so it was," replied Wellington; "for if I had rice and bullocks I had men; and if I had men I knew I could beat the enemy."

You have observed at this clinic that we make it a rule to allow the patient to tell her own story without interruption; and though it is sometimes tedious, and we are obliged to listen to much that has no bearing upon the case, still there is among the chaff now and then a grain of wheat that can be found in no other way, and without which the history of the case would be incomplete.

The patient having concluded her account of her illness, it is now our turn to ask such questions as we think requisite.

Time and practice are required to acquire skill in the cross-examination of patients; and when you remember how our friends the lawyers are obliged to practise the cross-questioning of witnesses before they become skilful examiners, you will not give up trying to improve, or be discouraged at your early failures. It is not often that the patient intentionally misleads the physician, but she may be embarrassed and confused, or, from extreme modesty, only half answer the questions; there is a *suppressio veri*, although there is no *allegatio falsi;* but by relieving her embarrassment by looking away from, instead of at, her, and so wording the inquiry that she shall understand your meaning and at the same time see that you are regarding her feelings, you will gain her confidence, and learn all that is requisite in regard to her ailment. It is important that you follow some regular system in your examinations of the patient. You may adopt whatever method you please, only so you have a method,—a place to begin, and know when you have gone over the whole ground. You have noticed that I divide the examination into functional, constitutional, and local: under the first head I inquire as to the frequency and character of the menstruation, number of pregnancies and abortions, and character of her labors; under the second, with regard to the sympathetic disturbances so commonly associated with disease of the womb, the condition of the digestive function; whether she has headache, palpitation of the heart, and in regard to the condition of all the organs remote from the uterus; and under the third, the locality and character of the pains in the pelvic region, the condition of the bladder, amount and character of vaginal discharge, if any. Having learned all you can by questioning your patient, you are now ready to make a physical examination. We will suppose, then, that the patient has been placed upon a firm

unyielding surface before a good light, that she is covered with a large sheet, her lower limbs flexed, and the knees allowed to fall well apart. You are now ready to do—what? introduce the speculum? No. That is what is too often done, and is just what you are not to do if you ever expect to become skilful in the diagnosis of uterine disease. It is not as a diagnostic but as a therapeutic instrument that you will find the speculum of the most service to you; but you have a diagnostic instrument, if I may use the term, in the index-finger of your right hand, worth more than any speculum that was ever invented. What I particularly desire to impress upon you is that at this stage of the examination there is nothing to be done with the speculum, and to call your attention to the importance of the much-neglected finger. After you have concluded the digital examination you may introduce the speculum, and look through it to verify the diagnosis you have made with the finger, so far as it relates to the os uteri; but not until a thorough digital examination has been made is the speculum to be thought of. Why, in fact, you don't even know what direction to give the instrument till you have ascertained the locality of the os with the finger; and then again you may do irreparable mischief. The worst case of hemorrhage from cancer of the womb I ever saw was caused by the introduction and expansion of the blades of a bivalve speculum, when a digital examination would have convinced the operator that it should not have been used. I dwell upon this point, gentlemen, even at the risk of being tedious, for I know from long experience that too much reliance is placed upon the speculum as an aid to diagnosis, and that a thorough examination with the finger is too often neglected. On the ticket issued by the late Prof. Mott, of New York, to the students attending his lectures on surgery, there was a hand with the index-finger extended, and in the end of that finger there was an eye; the meaning of which was that the student should so educate his finger that when occasion required him to pass it beneath the skin, he could see with it all that was there; and I am sure that in the diagnosis of the sexual diseases of females you will find nothing more important than the education and use of the finger, and by education I mean what I say. To be sure, it will take time for you to become skilful; but what do you think of the professional pianist who begins his studies with the understanding that he must practise four hours a day for eight or ten years before he can acquire that delicacy of touch that will rank him with first-class performers? and, as an evidence of the extent to which the finger may be educated, we have seen the blind able to detect and map out the colors of a dress by the sense of feeling alone.

It may be that some of you think I overestimate the value of the finger in the diagnosis of uterine disease. Let us go on with our examination, and see what we can learn by its use. First, we will wash our hands, for we should always before touching the sensitive mucous membrane of any patient be sure that the hands are free from impurity; then we will smear with lard or oil the first two fingers, for you can reach about an inch higher with the first and second than you can with the index-finger alone, and you will want to use both if you are not able to thoroughly explore the parts with one. We will take a seat before the patient, for considerable time may be occupied, and standing is tiresome. The vaginal canal being pervious, and the finger meeting with no obstructions, the first thing to be determined is the location of the os. Is it in the normal position of a healthy uterus, or is it low in the pelvic cavity, as in prolapsus or elongation of the neck? or high up, as when lifted by pregnancy or morbid growths? Is it tipped forward behind the pubis, as in retroversion of the fundus, or is it back by the sacrum, as in anteversion? Is the cervix larger than normal, as in congestion and inflammation? Is it hard, or is it soft? Is it hot and tender? and does it bleed on the slightest touch? Is the os well closed, or is it patulous? and is there exuding a thick gelatinous secretion? and is there present that soft velvety ring of granulation never to be mistaken by the educated finger, and never recognized by the careless examiner? Is the uterus movable in the pelvis, or is it fixed by cellulitis, the result of cancerous infiltration? and is there present the hard, unyielding border with the crumbly surface, and a tendency to bleed whenever touched? or do we find smooth hard lobes or knobs dotted over the end of the cervix, as in the early stage of cancer? and if so, we must be particular to examine whether the fissures between the elevations are all traceable to the os, for if that is the case, they are probably the result of laceration, and the irregularities are not the result of cancerous deposit. Then, passing the finger up behind the neck of the uterus, the os being in the normal position, do we find a lump there, due either to retroflexion, fibrous tumor, or impacted rectum? and in front is there one due to anteflexion, fibrous tumor, or stone in the bladder? Is the condition of the vagina normal? and is there anything to be discovered by pressure of the pelvic areolar tissue in all directions through the wall of the vagina? if not, then we may place the left hand on the abdomen, just above the pubis, and, by bimanual palpation, proceed to examine that part of the uterus out of reach of the finger, within the vagina. I have often been told by students that they found this conjoined manipulation unsatisfactory, and were unable to engage the uterus between the two hands. I am of the opinion that the cause of their failure has been that they endeavored to press the hand on the abdomen down to the uterus, when they should have lifted the uterus up to it with the other hand. With two fingers in the vagina, passed as far as possible up behind the neck of the uterus, you can lift it upwards and forwards, so that in all except very fat women the fundus can be readily felt with the hand on the abdomen, and the entire surface be examined. The posterior wall of the uterus may be examined by introducing the finger high up within the rectum, and at the same time drawing the uterus down with a tenaculum hooked into the posterior lip of the os. We must not expect the uterus to descend at once, but by steady traction we shall cause the supports to relax,

and shall be able to bring it down as far as is requisite. We can examine the recto-vaginal space by introducing the finger into the rectum and the thumb into the vagina. It is often necessary to examine the bladder, and this is by no means a difficult operation. The female urethra is so short and dilatable that I am in the habit constantly of introducing my finger within the bladder for purposes of exploration, and I am somewhat surprised that the condition of the bladder is so seldom investigated in this way by gynæcologists when there are so many cases in which it is out of order, and an examination with the finger so often clears up the diagnosis. The patient being etherized, it is only necessary to use the forceps or the uterine dilator to dilate the urethra enough to admit the end of the little finger, which, having first oiled, you introduce, and by rotating and pushing it gently forward for a few moments, it will pass through. Now withdraw it and introduce the tip of the index-finger in the same way until it passes into the bladder. There is, of course, some pain after the patient comes from under the influence of the ether, but this is remedied by an opiate; and the incontinence of urine is soon gone. I have never seen any bad results from the introduction of the finger within the bladder, and I have done it many times. There is not time in one lecture to even allude to all the obscure sexual difficulties that may be cleared up by a digital examination; but if in this hasty review of some of them I have convinced you of its importance as an aid in diagnosis, and you will improve your opportunities in the education and use of it, I shall be satisfied and you will be benefited. If we fail to discover the difficulty by a digital examination and with the use of the speculum, we must then explore the cavity of the uterus; and to aid us in this manipulation we have the uterine sound or probe. The one I prefer, and that I have shown you, is of small size, is made of copper, and is perfectly smooth. There are no marks to indicate the inches, and there is no knob two and a half inches from the end; these are of no use, and if you bend the instrument much, as you will be obliged to, you will find that it will be constantly breaking off at these indentations. When you wish to measure the depth of the uterine cavity, introduce the sound, carry the forceps up to the os and then withdraw the two together. Now, this sound is a very reliable diagnostic instrument, if used in a careful and thoughtful manner; and it is of no use, and is capable of doing great harm, if used carelessly. I should be sorry to have you think the introduction of and the exploration of the uterine cavity with the uterine sound an operation requiring no skill: on the contrary, it often taxes the patience of the most adroit; and I have seen most unfortunate results from its use by the inexperienced. A careful digital examination should always precede the use of the sound, for by it we learn the position of the uterus, and whether we have version or flexion to deal with; and then, and not till then, do we know how to shape the sound or what direction to give it. The instrument should always be oiled, and we may use the speculum or not, but I think you will find the operation much less difficult if you use the bivalve speculum than if you proceed without it. Sometimes the sound passes to the fundus of the uterus without any difficulty, but in many cases after you have passed it something more than an inch up the cervical canal, it meets with an obstruction, and the desire to use force to overcome the difficulty is almost irresistible; but this must not be done. If the sound does not go in, *the point of the instrument is not directed in the axis of the canal*, and you must withdraw it, and give it a different curve. If after repeated efforts you fail to introduce it, you will often succeed if you take the tenaculum and draw down the lower end of the uterus and hold it there while you pass the sound. In this way you straighten the canal, and the difficulty is removed. You will do well to remember what I have said about the sound, for I have been told by very many young physicians that they found difficulty in the use of it; and, as I have said before, cases are not uncommon where injury has been done with it. It is only a short time since I was called to the assistance of a young physician who, failing to recognize the case as one of anteflexion, had pushed the sound directly through the posterior wall of the uterus, and it was only arrested by coming in contact with the sacrum; fortunately, the patient recovered. The examination with the sound gives us information in regard to the depth and direction of the uterine cavity, and also as to the sensitiveness of the mucous membrane, but there are cases in which, both for diagnosis and treatment, it becomes necessary to dilate the canal sufficiently to admit the finger. There are several ways of accomplishing this. The parts may be rapidly dilated with the uterine dilator sufficiently to admit the finger far enough to complete the dilatation, or you may adopt the slower method of dilating with tents of sponge or sea-tangle. To introduce a sponge-tent, hook a tenaculum into the posterior lip of the os, and draw the cervix well down into the speculum, seize the tent with a strong forceps, dip it in oil, and by rotating it at the same time you push it forward, you will be able in most cases to introduce a tent large enough to complete the dilatation, and thereby avoid the necessity for the introduction of the second tent, for it is not a matter of indifference whether you use one tent or more. The reason is that on the removal of the first tent the mucous membrane is seen to be more or less abraded, and in the most favorable condition to absorb putrid discharges retained in contact by subsequent tents. Unfortunate results are so frequent from this cause that I invariably use one tent only, and if further dilatation be required use the finger or the uterine dilator.

TREATMENT OF VENEREAL WARTS AND CONDYLOMATA (*The Canada Medical Record*, July, 1874).—Wm. Bury recently cured two cases of venereal warts which had obstinately resisted treatment by strong nitric acid, sulphate of copper, and the scissors, by applying the acid nitrate of mercury followed by poultices of linseed meal. Two applications sufficed to make a perfect cure.

ORIGINAL COMMUNICATIONS.

A CASE OF MOVABLE EXUDATION IN THE TYMPANIC CAVITY, ATTENDED WITH VARIABLE HEARING.

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THE case about to be related is interesting from the fact that the diagnosis was greatly aided by the subjective symptoms.

Jacob Y., age 55, a large, strong man, a furnace-maker, applied for relief from deafness in the left ear, at the Infirmary for Diseases of the Ear, in June of this year. The patient stated that his right ear was greatly diseased when he was eight years old, and "that a polypus was taken from it, and the ear was then burnt with blue-stone." Since then he has had no hearing in that ear, and inspection reveals total occlusion of the auditory meatus by a diaphragm covered with skin. The skin, forming, as it were, the false or new fundus of the auditory meatus, is not very sensitive, and a paracentesis-needle may be pushed through it several millimetres until the instrument strikes bony tissue. The patient, a very intelligent man, states that when Politzer's or Valsalva's method of inflation is used he feels the air enter each middle ear alike. In this instance, however, he sought relief for an increasing deafness of recent origin in the left,—the heretofore good ear. He could assign no reason for its onset or persistence, as there had been no attack of pain nor any extraordinary event from which to date its occurrence. The drum-membrane presented nothing positively abnormal in its appearance, and as the right drum-membrane was wanting, the relative appearances of the good ear were of no value. The tuning-fork placed on the vertex was heard better in the right—the occluded ear—than in the left ear. External sounds—*i.e.*, sounds conveyed through the air—could not be heard at all in the right ear. The watch was heard $\frac{6 \text{ in.}}{40 \text{ ft.}}$ in the left ear, and the voice about three feet.

Catheterization of the left Eustachian tube forced air into the tympanic cavity, with moist râles, and was followed by considerable improvement in hearing, amounting to $\frac{12 \text{ in.}}{40 \text{ ft.}}$ for the watch, and six feet for the voice. The improvement in hearing persisted for two or three days, and then disappeared, the hearing sinking to six inches for the watch, below which it never fell. This treatment with the catheter was pursued for several weeks, with invariably the same results. There were no signs of faucial or nasal catarrh, and the membrana tympani remained unaltered in appearance. The patient at last stated that he had constantly felt a "drop (of fluid) in his ear," and that when he lay down at night he could hear as well as ever, but when he arose in the morning "the drop came back in his ear and he was deaf." After the narration of these subjective phenomena, the patient was placed in a chair, and told to bend his head alternately backward and forward, and upon doing so his hearing was found to *vary with the positions assumed*. He stated that as he moved his head he would "feel the drop move," and I discovered that he really could hear the watch twice as well in some positions as in others. This variable hearing was at its maximum when the head was thrown backward,—*i.e.*, when the position of the head most closely resembled that assumed when the patient was in a supine position in bed, and the hearing was at a minimum when the head was erect or thrown a little forward,—*i.e.*, in about the position the patient usually carried his head in the pursuit of his daily avocation.

From this examination, together with the statement of the subjective symptoms, I felt convinced that there was a collection of movable fluid within the tympanum, which caused this deafness, and that a paracentesis of the membrana tympani would relieve it. I then made a free incision in the postero-inferior quadrant of the membrana tympani, and a gentle inflation of the tympanum by Valsalva's method forced a large drop of light-yellow serum into the external auditory meatus. The patient instantly expressed great relief, saying that the "drop had gone, and that he could hear distinctly." I then found that the hearing had risen to $\frac{15 \text{ ft.}}{40 \text{ ft.}}$ for the watch, and the voice was heard normally.

The patient was instructed to inflate the tympanum by the method of Valsalva several times during the day, in order to thoroughly empty the tympanic cavity of all fluid. This course was pursued for forty-eight hours, at the expiration of which the perforation healed, and the *hearing remained normal.*

Remarks.—The presence and recognition of movable exudations in the tympanum have been fully described by Politzer several years ago (*Wiener Med. Wochenschr.*, 1867, and *Wiener Med. Presse*, 1869). The symptoms produced by their presence are deafness, altered appearance of the membrana tympani, and, if the membrana tympani is thin, visibility of the fluid contained in the tympanum. In such cases the level of the fluid appears as a dark line on the membrane, but, after catheterization, bubbles of air may take the place of the previously undisturbed fluid.

Cases similar to the one under consideration are thus accounted for by Politzer, *loc. cit.*, 1869, p. 2: "Closure of the Eustachian tube causes a rarefaction of the air in the tympanum. The diminished pressure thus produced upon the vessels of the tympanum, already distended by hyperæmia, permits a ready escape of serous fluid through the walls of the vessels."

In the case just described, deafness more or less relieved by the catheterization of the Eustachian tube, the subjective symptom already described as "the drop," and the variable hearing as revealed by the watch, were the prominent symptoms.

The appearances of the membrana tympani were unaltered excepting a slight retraction, and the fluid contents of the tympanum were, of course, invisible through the drum-membrane.

The deafness in this instance was caused by the impeding influence of the fluid in the tympanic cavity upon the ossicula auditus and the fenestræ of the labyrinth. The temporary relief afforded to the hearing by the catheter was due to the unloading of the chain of bones and the fenestræ, and the resumption of their vibratable functions. "The drop" was the perception by the patient of the motions of the fluid contained in the tympanic cavity, and the variable hearing produced by the positions of the head of the patient was caused by a partial unloading of the conducting apparatus of the ear, as the fluid gravitated under various attitudes assumed by the patient, into portions of the tympanum remote from the ossicles and the fenestræ.

In conclusion, I would draw attention to a phenomenon observed in this case, and in other

cases, of fluid accumulation behind the drum-membrane.

At the moment the knife touched the membrana tympani I failed to perceive the peculiar sound as well as the sensation communicated through the instrument as it touches a tightly-stretched and isolated membrane. This is due to the fact that the membrana tympani was so much encroached upon by the fluid contained in the tympanum that it no longer acted as an isolated membrane. I would therefore add this peculiar doughy or inelastic feeling in the membrana tympani to the diagnostic signs of an accumulation of fluid behind the membrane, and I consider it one of especial benefit in a case like this, where there were none of the peculiar ocular manifestations which usually characterize this condition of the ear.

This fact might be utilized before the operation by gently percussing the membrana tympani with a delicate blunt probe, which would elicit the peculiar acoustic effect of an isolated membrane if the membrana tympani were unimpeded; or if the membrana tympani had ceased to act as an isolated membrane, the proposed percussion would reveal the fact by the doughy sensation or dull sound produced by the properly manipulated probe.

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NOTES OF HOSPITAL PRACTICE.

UNIVERSITY OF PENNSYLVANIA.

CLINIC OF DR. J. E. GARRETSON.

DIAGNOSIS OF A TUMOR.

GENTLEMEN,—I have taken occasion very frequently to say to you that to diagnose the character of a tumor for purposes of treatment does not seem at all a difficult matter, for the reason that there are, clinically speaking, but two kinds of tumors, and any morbid enlargement with which we meet will be found to belong to the one or other of these classes.

A tumor has in itself the explanation of its existence; or otherwise it is without such self-explanation. A tumor belonging to the first class contains its own history, and suggests of itself the character of treatment demanded. A tumor belonging to the second class tells nothing, and leaves us to our own inferences.

Tumors of the first class are, in themselves, necessarily benign.

Tumors of the second class are found almost certainly to prove cancerous.*

Benign tumors are of multitudinous signification. Examples: ranula, hernia, wens, etc.

Cancerous tumors, however they may differ in expression, are of a common meaning. There is but one cancer, and we may agree with the English school of pathology in viewing it as a disease of constitutional signification, and not with Virchow, Woodward, and their adherents, who esteem it as being primarily of local origin.

The self-explaining tumors demand for their recognition the possession of anatomical and physiological knowledge sufficient for the reading of their riddles. For example, he who discovers in a tumor of the groin an undescended testicle must know of the meaning of the inguinal canal; he who diagnoses a sebaceous cyst is to read the perversion in a knowledge of the oil-secreting glands; he who recognizes a ranula must have understanding of the salivary outlets. Knowing of all the associations of a part in which a tumor appears, he is to find the meaning of the tumor—if it has local meaning—in the *something* which is seen to be wrong.

Let us suppose, however, that we meet with a tumor in a part,—in any part,—and that we find ourselves unable to explain its presence in any derangement of the part. What is to be the conclusion? We are to infer either that we are ignorant concerning the relations, or else, being satisfied that we know properly and fully the locality, that the tumor is not one of local, but of systemic meaning. It would be for us, then, if satisfied of the latter conclusion, to consider tumors of constitutional expression. And here, through exclusion, we would very quickly be able to determine whether or not we had to deal with scrofulosis, the venereal disease, or with *that something* of which we know so little,—the cancervice.

As an example of each manner in diagnosis, I now bring before you five patients, every one of whom has a tumor occupying the same locality, and all being of a common appearance.

[The cut is taken from a photograph of one of the five, who died, a few months subsequently, from cancer. —Case V.]

Case I.—The history of this case exhibits it as one of acute signification. The trouble commenced, as the patient tells us, in an aching tooth. Opening the mouth, we remark at once a lower molar evidently raised in its socket, and about which there is much inflammation. This, as the *something wrong*, we see, and we see nothing else in the way of a cause. Without enlarging on the subject, I may say that, let the tumor prove what it will, the most sensible thing to be done is either to remove the tooth we find diseased, or otherwise treat it. This we are to do because we know the tumor to be an enlargement of the submaxillary gland, and, finding no other cause for such enlargement than the one just discovered, we may not possibly do anything better than so direct our treatment. This tumor, I hold, explains itself as a sympathetic enlargement of the salivary gland. The cure of the enlargement will be found in the cure of that which irritates the region. We will extract the tooth.

Case II.—Here we have a second tumor in the submaxillary region; differing, however, from the first, in being less circumscribed. The history of this case expresses it also as of acute signification, although it certainly would not be necessary to learn this of the patient, remarking the characteristic features of all the expressions. The parts are very red and very hot; they may only be very painful.

Attempting to open the mouth of this patient, we discover that she has a broken lower jaw,—and this accident has resulted from the stroke of a brick. We will cure this tumor by curing the broken bone,—by putting the parts in a splint and thus securing rest, and by employing such local antiphlogistic means as may prove to be required. Certainly this tumor explains itself.

Case III.—In an examination of this case, I expose to you caries of the jaw; and if for a single moment you glance at the decaying and otherwise diseased

* A single exception to the placing of tumors into two classes exists in the case of hydatid growths.

mass of overlying teeth, you will be at no loss to account for the trouble of the bone. This is another instance in which the tumor originates in sympathy with a local disturbance, and explains itself. Our treatment here will be, first, to remove the teeth; second, to scrape away the dead and dying portion of the maxilla. The cure of the caries will prove the cure of the morbid enlargement. Or, having operated on the bone, we will, not unlikely, find advantage in applying to the face of the tumor a mixture of equal parts of tincture of iodine and olive oil. Alluding to this combination, I might direct your attention, in passing, to its efficacy in all cases of subacute or chronic inflammations; I have come to depend on it as a kind of specific.

Case IV.—The tumor we here find secondary to necrosis of the jaw, and the necrosis has its origin in conditions of strictly local signification. Any one of you can here explain the cause of the enlargement, and judge as to what is to be done to effect a cure. We must wait for a complete exfoliation of the sequestrum, and then remove it. The tumor will take care of itself.

Case V.—Here is a fifth tumor, having a common appearance with the others; palpation, however, discovers a difference. This tumor seems to the touch to be more or less lobulated; it is also very hard. It is without pain on pressure, but has occasional sharp, sting-like sensations running through it.

Not unnecessarily to detain you, I would say that before bringing this patient into the room, I made a thorough examination of the case with a view to finding a cause for the tumor, but the search resulted in nothing: that is to say, this young man has no bad teeth; no lesion from accident; no caries; no necrosis; no local anything that explains his condition. In a search continued in the constitutional direction, I have succeeded no better. There is no scrofulosis; no tuberculosis; no venereal disease; no anything familiar to us, that directs how to act in the case. Now, because the tumor is independent of common causes of irritation, I know of no better practice than to view it as an expression of cancer, and so direct our practice. In other words, let the enlargement alone, and wait developments; for if it should prove that the disease is cancer, having no specific for such a vice, we find ourselves powerless; certainly the knife could not be used on the tumor before us, as it is without distinctness of boundary, and to meddle with true cancer so situated with sorbefacient and other preparations is to do nothing but harm. If, on the contrary, this tumor should not prove to be cancerous, we certainly act with greatest show of wisdom in doing nothing until we find out what is to be done—*secundum artem.*

I take it upon my experience, however, to say that in three months I will exhibit this particular case again before you, in the condition of fungus hæmatodes. I take it upon myself to declare the tumor cancerous, on the simple ground that it declares itself to be nothing different.

UNIVERSITY HOSPITAL.

SURGICAL CLINIC OF PROF. AGNEW, SEPT. 16, 1874.

TWO CASES OF HYDROCELE.

TWO cases of hydrocele were presented,—one in a boy 2½ years of age, the other in a man of 30 years. In both, the complaint had existed for several months; occupying in the child the right side, and in the adult the left side of the scrotum. Prof. Agnew said that the tumor for which hydrocele in a child is most liable to be mistaken is hernia, but there are several points of difference which render the diagnosis not difficult. If we study the characteristics of a hydrocele we find it to be an oval or pyriform tumor, uniform in outline, translucent by transmitted light, permanent, and giving to the touch a characteristic elastic feel. Hernia is apt to be more or less irregular in outline, but may present very much the shape of a hydrocele; it is not translucent, though the hernial sac may contain sufficient serous fluid to render a portion of the tumor pervious to light. It is not a constant tumor, but, unless strangulated (in which case there are symptoms which give unmistakable evidence of the condition), disappears when the patient assumes a recumbent posture, or may be easily reduced by proper manipulation. The fingers placed upon a hernial tumor feel an impulse from the acts of coughing, crying, etc. Besides, a hernia first appears at the abdominal ring, or in the canal, and grows downward, while in hydrocele of the tunica vaginalis testis the swelling begins below and extends upwards. In the adult there are other tumors from which we are obliged to diagnose hydrocele: enlarged testicle, tubercular, cystic, and cancerous diseases of the gland. One characteristic of all these is their increased weight as compared with hydrocele; another is the entire absence of translucency. The very rapid growth of malignant sarcocele is an important diagnostic sign. The treatment of hydrocele is of two kinds: palliative and curative. The former consists in evacuating the tumor by puncture with trocar and canula; the curative treatment varies with the age of the patient. In children of the age of the youngest of these patients, or younger, the fluid will sometimes be absorbed under the influence of external applications of a solution of muriate of ammonia or of tincture of iodine; but a more satisfactory method is the introduction of a thread through the walls of the sac. In the adult the most satisfactory method is the puncture of the sac, evacuation of its contents, and the injection of tincture of iodine. The first patient was etherized, and a silk thread introduced through the walls of the tumor, the ends being tied loosely together; the contents of the sac were then allowed to escape. Prof. Agnew directed that the thread be removed in twenty-four hours, by which time sufficient irritation would be excited to effect a cure. The other case was first tapped, and the fluid drawn off in the usual manner. A little more than ʒij of tincture of iodine was then injected, and allowed to remain.

Prof. Agnew said that it was essential to a favorable result to retain the iodine in the cavity of the sac, and its withdrawal by some operators he considered the cause of failure with them in the use of this agent; that he believed if the operation be performed as directed, and a sufficient quantity injected (ʒij to ʒijss), a cure would be effected in all cases unless the hydrocele be of extraordinary size. The patient was directed to return immediately to his home and go to bed. The lecturer said that active inflammatory symptoms would soon manifest themselves, and the part would swell greatly, and require careful support. Five or six days after the operation the patient may usually be allowed to rise from bed, being careful to continue the support of the scrotum by a suspensory bandage. Should the inflammation excited by the operation be too violent,—a very rare occurrence,—local applications of lead-water and laudanum may be required. In the course of a few weeks the swelling will have completely subsided and a cure be effected. Prof. Agnew spoke of the necessity of a careful examination after drawing off the fluid of hydrocele, to ascertain that it be not complicated by hernia or organic disease of the testicle, which last condition contra-indicates the use of iodine injections.

COLLE'S FRACTURE OF RADIUS.

The next patient was a woman 37 years of age, with a fracture of the lower end of the left radius of the kind

usually known as Colle's fracture. This was the result of a fall upon the extended hand, occurring four days ago. Prof. Agnew described the three kinds of fracture of the lower end of the radius, to which the names of Barton, Colle, and Smith are given respectively. The first is a rare form, and only includes fractures extending into the wrist-joint. Barton described two forms of this fracture: one in which the fracture extended from the palmar to the dorsal surface of the bone, and obliquely from without downward and inwards, separating the styloid process of the radius; the other extending from the outer to the inner side, and from the dorsal surface obliquely downwards into the joint, detaching the dorsal border of the articulating extremity.

The name of Colle's fracture is given to any fracture of the radius below a point two and a half inches from its extremity, which does not enter the joint. Smith's fracture occurs at a distance of at least two and a half inches from the end of the radius. The treatment of all these different forms is essentially the same, being directed to the reduction of a deformity which consists in the displacement of the lower fragment and hand backward and to the radial side. This deformity is more marked usually in those fractures occurring very near the extremity of the bone; particularly if the fracture be oblique and complicated by dislocation of the lower end of the ulna, in which case the styloid process of this bone projects conspicuously.

Prof. Agnew said he considered the best method of treating these fractures was by Bond's splint, the shape of which abducts the hand strongly to the ulnar side. The hand grasping the block at the extremity of the splint admits of motion of the fingers, which Prof. A. considers of great importance in preserving the usefulness of the hand. At the same time the antero-posterior deformity is corrected by the use of wedge-shaped pads, one of which is placed upon the dorsal surface over the lower fragment with the base upward, the other on the palmar surface with the base corresponding with the line of fracture looking downward. This had been the treatment in this case, and was continued.

The lecturer called attention to a discoloration highly characteristic of fracture, which is due to hemorrhage from the fractured surfaces, and which does not make its appearance externally for several days after receipt of injury. This is to be distinguished from discoloration due to rupture of more superficial vessels.

TRANSLATIONS.

Traumatic Neuralgia.—At the recent meeting of the French Association for the Advancement of Science, reported in the *Gazette Hebdomadaire*, September 11, M. Verneuil called attention to a complication of traumatic lesions which, without being very grave, is yet painful, and capable of retarding the work of reparation. It consists in painful sensations, more or less acutely perceived in the wounded locality, in its neighborhood, or even at a considerable distance, supervening during the first few days subsequent to the accident.

These sensations affect a neuralgic character and intermittent type, are not to be explained by ordinary causes of traumatic suffering, resist the ordinary antiphlogistics and narcotics, and yield without difficulty to sulphate of quinine.

M. Verneuil gives this complication the name of *traumatic secondary precocious neuralgia*. Pain is essentially the predominant symptom; its onset is generally sudden, and, once established, it may be continuous or remittent, or more frequently intermittent, with daily attacks.

Concurrently, contractions or a certain degree of powerlessness of the muscles may be observed. This condition is generally limited to the parts near the wound. Vascular troubles may also exist, strictly due, to all appearance, to the existence of the local pains, and these may even provoke secondary hemorrhages. The wound passes through various modifications. Sometimes it preserves its normal appearance; sometimes it presents a diphtheroid aspect; sometimes even it may become the seat of a true phlegmonous inflammation. These various conditions are only effects of the neuralgia, since they yield very rapidly to sulphate of quinine.

What is the cause of this neuralgia? Is it neuritis, modification of the nervous conductors, etc.? The details of various observations, says M. Verneuil, do not point to the possibility of a pathological cause of this kind; but if the explanation of this neuralgia is not found in traumatism, its seat or its varieties, it may be recognized as having an intimate relation to anterior diathetic conditions or to the previous health of the individual.

These various facts permit the establishment of a diagnosis without difficulty, and allow also of the opportune application of the treatment, which is administration of quinine in proper doses, at regular intervals, and for a sufficient time. A. V. H.

Ligation of the Interosseous Arteries of the Fore-arm (*Acad. de Méd.*, September 15).—M. Gosselin read for the author, Prof. Michel, of Nancy, the following communication: In a patient who had received a gunshot wound, producing fracture of the superior extremity of the radius, such profuse hemorrhage supervened that M. Michel was obliged to ligate successively the brachial, in the lower fourth, the radial, the ulnar arteries, in the upper third, and, finally, the trunk of the interosseous. It was not until after the ligation of the latter, now performed for the first time, and heretofore avoided by operators on account of its difficulties, that the hemorrhage was completely arrested.

The following was the operative procedure adopted by M. Michel:

The direction of the muscular interstice of the anterior ulnar and of the flexor sublimis digitorum was traced, and a line drawn from the internal side of the pisiform bone to the epitrochlea as if for the ligation of the ulnar in its superior third.

On this line a cutaneous incision was made three inches at least in length, of which the centre corresponded to the bicipital tuberosity of the radius. The muscular interstice was then divided almost to its superior extremity. Then, flexing the wrist on the fore-arm and the fingers on the hand so as to entirely separate and divide the superficial from the deep flexor above, the origin of the ulnar could be perceived.

Following its posterior aspect, the origin of the trunk of the interosseous could be plainly perceived, enveloped by its accompanying veins. These surroundings rendered the isolation of the vessel a somewhat delicate matter, but one which was surmounted by the exercise of patience. This process by practice becomes easy, and in a short time may become familiar even to students.

The author terminates by the following conclusions:

1. The trunk of the interosseous may become the origin of severe traumatic hemorrhages of the fore-arm and hand.

2. There is every reason, therefore, why the ligation of this artery should be among the procedures of operative surgery.—*Gaz. Méd. de Paris*, September 19, 1874.

A. V. H.

PHILADELPHIA

MEDICAL TIMES.

A WEEKLY JOURNAL OF

MEDICAL AND SURGICAL SCIENCE.

The Philadelphia Medical Times is an independent journal, devoted to no ends or interests whatever but those common to all who cultivate the science of medicine. Its columns are open to all those who wish to express their views on any subject coming within its legitimate sphere.

We invite contributions, reports of cases, notes and queries, medical news, and whatever may tend to increase the value of our pages.

All communications must bear the name of the sender (whether the name is to be published or not), and should be addressed to Editor Philadelphia Medical Times, care of the Publishers.

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EDITORIAL.

TRANSACTIONS OF THE MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

FOR reasons which have been adduced in previous editorials of this journal, it is a matter of grave doubt whether the American Medical Association ever can assume a paramount importance to the profession at large, or ever approximate in this country to the influence wielded by the British Medical Association in Great Britain. These reasons, however, do not apply to the State Medical Societies. Citizens of one commonwealth,—governed, therefore, by the one law and domineered by the same customs,—inhabitants of a territorial district not too large to forbid free intercourse, the members of a State society are in a position to be readily fused into that unity which can alone give strength to a medical association. Believing, as we are inclined to, that the hope of the profession for the future, nay, rather, the very existence of the profession as a profession, lies in the State societies, it is with the greatest of interest that we have examined the Transactions before us. The result is eminently satisfactory. In the brief space of an editorial we can only comment upon a few points which have especially attracted our attention, and must omit notice of much that is worthy of praise. An objection to the eloquent address of the President may be made by some that it is too theological; but since it has become the fashion for scientists to prolong their vision across the invisible, and mistake for wisdom their own illogical reasonings, it is well, occasionally, to hear a little orthodoxy.

The address on obstetrics is a very elaborate, well-written résumé of recent literature, and must be of especially great value to those who have not access to the libraries of large cities. The address on surgery is really an article on tracheotomy, and we leave the judgment of its value to our surgical friends.

The *pièce de résistance* of the volume is a very learned, laborious article on croup in its relations to tracheotomy, by Dr. Cohen, of this city. It is a paper that should be studied by every man who expects to attempt such operation or to decide as to the propriety of its performance.

The reports of the county medical societies are all of them interesting; containing, it is true, many matters concerning local epidemics as well as medical geology and geography scarcely of general interest, but containing also reports of strange and instructive cases, many good suggestions in therapeutics, and other matters worthy of general attention. We confess that we have been somewhat surprised at the literary ability displayed in most of them, and sincerely wish some of our city contributors would take lessons in English of their authors. We would especially cite, as suggestive, Dr. Corson's remarks on the treatment of pneumonia, and, as remarkable, a case reported by Dr. Randenbush, in which the patient recovered although he had been run through the chest with a scythe, which he had pulled out with his own hands. "The curvature of the scythe cut from the point of entrance obliquely downwards and to the right, severing the cartilage of the third rib on the left side, the sternum and cartilage of the fourth rib on the right side, making a wound in the chest anteriorly six inches in length. The posterior or wound of exit was about two inches long, or the width of the scythe."

Dr. P. R. Palm, of Allentown, states that the root of the Asarum Canadense is used in his neighborhood for the production of abortion, and details a case. We had supposed our "wild ginger" was as harmless as peppermint, but certainly the evidence brought forward is remarkable and staggering.

During the year the Society has lost by death the member by whose act it was called into being. It was Dr. Wilmer Worthington who offered, at a meeting of the Chester County Medical Society, in 1847, the preamble and resolutions which led to the organization of the State Society, and to him, there-

fore, the profession of the State owes a debt of gratitude, enhanced by a singularly useful and unselfish public life of many years.

Dr. Worthington was an enthusiastic advocate of everything calculated to elevate the general tone of the profession; doing all that lay in his power by word and by deed. As he has laid the foundations, so we hope others will build; organizing and consolidating the State Society until it becomes a body whose word is paramount in its district, and until it is able to use its influence with success in enforcing upon candidates for professional honors that higher general culture, and more extended and thorough technical education, for which Dr. Worthington so earnestly pleaded.

Any one in doubt as to how much or how little scientific capital is required to fit up a showy *Tribune* bulk-window should read the replies to Dr. Hammond's defence in the last issue of the *New York Medical Journal*. The London *Medical Record* characterizes Dr. Hammond's proposed treatment as "utterly ridiculous." The *Boston Medical and Surgical Journal* speaks of his "having brilliantly closed the hydrophobia season." Some of the Western press have been very outspoken and severe: indeed, we believe the general expression of opinion has been such that it will have a salutary effect in restraining the spread of the newspaper epidemic.

The English colliers appear to appreciate the importance of sanitation. It is stated that eight hundred men at the Windon Collieries in Durham have suffered for a long time from improper water-supply, and have made many complaints to their employers. The latter refusing to listen to these representations, the men have struck. The Durham Pit Villages are said to be an abomination upon the face of the earth, and we hope the laborers will be successful in forcing their employers to give them suitable dwellings.

The "quiz" advertisement to which we alluded in a recent editorial was printed in a column of the paper allotted to advertisements, and in the type and dress of an advertisement. Our judgment was therefore, from the premises, seemingly an inevitable one. Outside evidence has, however, since been brought to our knowledge, showing that the matter was put in the paper by an over-zealous reporter, without the knowledge of the quiz organization.

The famous London surgeon, J. Erich Erichsen, has recently been on a visit to this city, and was the recipient of a complimentary dinner from a number of medical gentlemen, including most of the prominent medical teachers and authors of our commonwealth. The affair was an exceedingly happy one in all particulars.

Dr. A. J. Eidson (*The Amer. Med. Journal*, Oct. 1874,—Eclectic) has discovered that labor is greatly facilitated by placing the head of the woman towards the north. Difficult cases should be sent to the magnetic pole.

The London *Lancet* says, "A contemporary states that a fee of $150,000 was lately paid to an American surgeon for removing a wen by means of the galvano-cautery."

Who was the fortunate man? We suspect the "contemporary" must have been Mark Twain's organ.

CORRESPONDENCE.

NEW YORK SOCIETIES.

New York, October 6, 1874.

INSANITY OF INEBRIETY.

The New York Neurological Society held a regular stated monthly meeting last evening, at which two very interesting papers were read: one by Dr. George Burr, of Binghamton, New York, on the Insanity of Inebriety, and the other by James J. O'Dea, of Clifton, Staten Island, New York, entitled, The Philosophy of Suicide.

Dr. Burr remarked substantially as follows:

It has been said many times, when an individual has been seen to sacrifice all consideration and prospect in life for the gratification of a desire for ardent spirits, that such a man must be crazy; that no sane man or woman would thus throw themselves away, and bring ruin upon every hope of the future. This view of the question is but a natural common-sense view; and yet it is held by comparatively few. The most common sentiment is that drunkenness is a vice,—a voluntary act of the subject,—for which he is morally and in every other way responsible. The object of the paper was to trace the relation of most of the forms of inebriety to an impulse as completely morbid as is to be witnessed in well-recognized varieties of impulsive mental derangement. By the term inebriety is meant a condition of the system calling for and demanding, through its sentient apparatus, the immoderate use of alcoholic drinks, either daily or at stated periods, according to the peculiarities of the case. The term does not mean merely a state of intoxication. Neither does it imply any particular effect of alcohol in any form upon the various organs and tissues of the body, nor that condition of the organization which Marcet has so well described as chronic alcoholism. All these are the effects, the consequences, of the indulgence. Other terms are frequently employed to designate this condition, such as methomania, dipsomania, propensity,

thirst. But the term dipsomania—meaning crazy for drink—is the most expressive.

There exists among all nations an inherent desire for ardent stimulants; and this propensity may be divided into two varieties,—1, a normal, healthy desire for stimulants to a moderate extent; 2, an augmented and inordinate demand, entirely at variance with a sound and healthful condition of the body or with its legitimate demands, and impelling the subject of it to acts of debasement and drunkenness.

In 1833, Dr. Woodward, of the Worcester (Massachusetts) Insane Hospital, in a series of essays, maintained that intemperance was a disease, and declared, from his own experience in the management of many hundreds of intemperate persons who had committed crimes which rendered confinement necessary, or who were insane in consequence of this habit, that this disease was amenable to treatment, and that "a large proportion of the intemperate in a well-conducted institution would be radically cured, and would again go into society with health re-established, diseased appetite removed, with principles of temperance well grounded and thoroughly understood, so that they would be afterwards safe and sober men." It must be here remarked that opinions like this have reference only to extreme forms of inebriety; the milder forms have usually been considered to be wicked or vicious indulgences censurable in the highest degree. The speaker differed from these views. He would refer every case of well-marked departure from a normal desire in the use of ardent spirits to the presence of some morbid influence. The difference between the severer and the milder forms of inebriety is one of degree only; the essential nature of each and their pathognomonic symptoms are the same.

The seat of this disease is undoubtedly in the sentient apparatus. It is, however, not to be referred to any particular pair of nerve-trunks, either to the pneumogastric, the glosso-pharyngeal, or the gustatory branch of the fifth pair; but, like the sense of hunger and thirst, or that of the *besoin de respirer*, it prevails throughout the entire organism. It is a morbid perversion of the natural sense. The impressions made upon the sensorium are false and unreal; unnatural wants are created by disordered nerve-communication, and unnatural sensations are experienced. In this respect these sensations somewhat resemble the hallucinations of sight and sound, when, as is well known, false impressions are made upon the eye and ear, and persons see unreal sights and hear unreal sounds.

The insanity of inebriety consists in the almost absolute power exercised by the morbid appetite over the operations of the mind, exciting ideas, emotions, and passions entirely at variance with the natural characteristics of the individual. The milder types consist of an abandonment of the individual to the influence of alcohol. He is impelled to commit acts which his sound and sober judgment would condemn. He does not have liberty of action, but must obey the strong uncompromising impulse which pervades his entire organism. He must drink, notwithstanding poverty is coming in at the door, and starvation is staring his family in the face, and his character and reputation are passing away "like a summer cloud;" nevertheless he must drink! The parallel between the morbid impulse to drink and other and well-recognized branches of morbid impulse, as well as other forms of mental disorders, is very striking; and the exciting causes will be found to be identical. It may be safely asserted that the ratio of insane to the population of the United States is probably greater than in any other nation; and this for very good reasons. The wear and tear of life is more severe here than elsewhere: the great desire to accumulate wealth, the rage for speculation, the constant recurrence of political campaigns, and a certain amount of religious fanaticism, are causes that are constantly operating to disturb and exhaust mental energy. No time is given to recuperate wasted energies. What wonder, then, that many fall out, and the faculties become deranged! These same causes operate to excite inebriety, only, it is believed, in a much larger ratio. Compared with the number of insane, the number of inebriates must be tenfold. These causes augment and intensify the desire for stimulants. Alcoholic and kindred drinks are immediately resorted to, and the diseased appetite is immediately inaugurated.

Among the special causes of intemperance, which, in one case, induces disordered sentiments or feelings, in another, a disordered mind, and in another, a disordered appetite, are a blow upon the head, and concussion of the brain from a fall. In one, the injury has been succeeded by a mania proper; in a second, a complete transformation of character; while in a third is developed a love for ardent spirits. Other causes are, inheritance, irritation, suggestion; and in no variety of morbid impulse does *habit* have a more potent effect.

In conclusion, he reiterated his theory that the habit of drinking is caused by a disordered state of the mind. To refer the self-destructive acts of the inebriate to the same influences which in others incite to kill, to commit suicide, to steal, or to burn, appears to him to be consistent and proper. Whatever gentlemen may think, all will no doubt concur in the propriety of studying the subject from this stand-point, in the earnest hope that eventually some remedy will be found, some check be placed upon the sad and fearful ravages of inebriety. In relation to inebriate asylums, the essayist is a firm believer in the utility of public institutions for the exclusive treatment of inebriates. In this he was aware that he differed from the learned President of this Society (Dr. Hammond), whose late comments upon the management of inebriate asylums he regards as too sweeping and denunciatory. He admitted the justness of the learned gentleman's criticism, to a certain extent, upon the present management of the institutions now in operation. The means of restraint employed are, perhaps, not adequate; but it will be found that one of the most difficult problems to solve ever attempted is the proper adjustment, discipline, care, and treatment of inebriates. Many of the regulations must be sub-

mitted to voluntarily, and the patient himself must earnestly co-operate in every measure calculated to promote his reformation. He must not only concur, but he must co-operate in all such measures. In the New York State Inebriate Asylum, at Binghamton, from the 1st of September, 1873, to the 1st of September, 1874, the number of patients admitted was 190. Of these 23, or 13⅓ per cent., have proved refractory and unsubmissive. The rest have quietly submitted to the rules and discipline of the institution; and many have gone out, as is believed, fully restored. Measures are now being taken to inquire into the subsequent history of all those who have been inmates of the institution. A small proportion relapse. Of the 190 inmates during 1873-4, 1 has returned three times, and 16 are there for the second term of treatment. But there is a propensity to return in many diseases, especially when the person is exposed to the exciting causes. Mental disorders, as is well known, are very liable to return; and the records of the lunatic asylums will probably show quite as many relapses in proportion as will the inebriate institutions.

THE PHILOSOPHY OF SUICIDE.

By the term suicide we are to understand the intentional destruction of one's own life. It embraces all who kill themselves intentionally, or, as the legal phrase expresses it, "with malice aforethought," whatever be the cause of the act or the mental condition of the agent. It excludes those whose death results from immoderate self-indulgence or the too ardent pursuit of a favorite scheme. Fundamentally, suicide has reference to the individual in his personal and relational life. Its causes are of three main orders: general, special, and personal. The general order of causes exists everywhere and under all circumstances, and includes religious belief, philosophy, age, and sex. The special order is that which is more circumscribed in range. It comprises all the various circumstances and accidents growing out of the social relations of the individual,—love-troubles, domestic difficulties, legal entanglements, habits of intemperance and immorality, financial losses and embarrassments. The personal order of causes has reference chiefly to the bodily and mental health of the individual.

It would be impossible in these short notes to do justice to the paper of Dr. O'Dea, which he intends to continue from time to time, treating the subject thoroughly. The following table, however, of suicides of ancient Greeks and Romans, together with a few remarks on the influence of sex and age on suicides, may be of interest:

NAME.	MODE.	CAUSE.
Pythagoras	Starvation	Tædium vitæ.
Demosthenes	Starvation	Downfall of Athens.
Clitomachus	?	Tædium vitæ.
Stilpo	Intoxication	?
Metrocles	Suffocation	Old age.
Menippus	Hanging	Financial losses.
Demonax	Starvation	Loss of influence consequent on old age.
Zeno	Strangulation	Fracture of a finger.
Seneca	Phlebotomy	Political reasons.
Pauline, wife of Seneca	Phlebotomy	An attempt caused by unwillingness to survive her husband.
Cato	Wound	Political reasons.
Otho	Wound	Political reasons.
Panthea	Poison	Grief at the loss of her husband in battle.
Phila	Poison	Defeat and flight of her husband.
Arria	Wound	Defeat and arrest of her husband.
Scipio	Wound	Because he had fallen into the hands of his enemies.
Socrates	Starvation	The victory of Philip at Chæronea.
C. Lutatius	Suffocation	To avoid falling into the hands of Marius.
Lollius	Wound	The ill-will of Caius Cæsar.
Nero	Wound	Because condemned to death by the Roman Senate and people.
Lycambus	Hanging	Ridicule.
Lambianus	Self-interment	Because his writings were condemned and burned.
Aristarchus	?	A dropsy.
Erasistratus	Poison	An ulcer.
Eratosthenes	?	Loss of sight.
Silvius Italicus	Starvation	An incurable disease.
Diogenes	?	A violent fever.
Porcia	Swallowed live coals	Domestic affliction.

The influence of age upon suicide is a study of more than speculative interest, on account of its practical bearings and of the ease and precision with which it can be demonstrated. By age is meant the critical periods of life. These periods having many components besides the mere fact of years, it is apparent that what we have to examine is a many-sided phenomenon, including together with it the advance in life, the workings of physiological, mental, and sociological causes.

The maximum of suicides for both sexes occurs between the ages of 25 and 55. Previous to the twenty-fifth year there is a sudden increase from two suicides between the ages of 5 and 10 to one hundred and thirty-six between 20 and 25. After 55 the tendency to suicide declines, but more gradually than it rose, except at 65, where the number increases from eighty-one to eighty-three,—a rise so slight, however, as to be little worth considering.

There are, therefore, three suicidal periods in life: those of organic and mental growth, of organic and mental completion, and of organic and mental decline. In the first the chart shows 80; in the second, 942; and in the third, 311. Comparing the periods in round numbers, it may be said that they are as one for childhood and adolescence to twelve for adult life and to four for the years of bodily and mental decay.

The influence of sex and its attending circumstances upon suicide at the different periods of life is shown upon the charts. With females, as among males, there is a sudden and abrupt rise until the twenty-fifth year is reached. This rise is continued to the thirty-fifth year, at which the maximum of suicides occurs among women. The period from the twenty-fifth to the thirty-fifth year corresponds to that of the greatest pressure from domestic troubles and responsibilities, and also with the greatest activity of the maternal functions. The line thence descends abruptly to the forty-fifth year, whence it rises to the fiftieth—the critical period of mature female life,—and then goes down, down, until it reaches the level from which it started.

There are, therefore, two culminating points, and whilst the line on the male chart is undulating and sustained, that on the female chart is vertical and abrupt. The lower of the male culminating points is the higher of the female, and, contrariwise, the lower of the female is the higher of the male.

These charts do not show the relative frequency of suicides among the two sexes. The ratio of suicides to population in the United States is (for the period covered by the last decennial census) 25 to 100,000 among males, and 3 to 100,000 among females. The only periods at which suicides are nearly equal for both sexes is from 15 to 20 years, during which the number of boy-suicides was 34, of girl-suicides 32. After this the number of suicides among males is much greater than among females.

W.

SELECTIONS.

PREVENTION AND TREATMENT OF PUERPERAL DISEASES.

[We have extracted the following paper from the American Supplement to the *Obstetrical Journal of Great Britain and Ireland*, because it seems to us worthy of being read by the general profession, as embodying views and actions exceedingly novel and successful on a most important practical subject.]

THE Preston Retreat is a small lying-in hospital for reputable married women. The yearly average has thus far been about one hundred labors, but it is now rapidly increasing. It contains four wards, each with a capacity of 9153 cubic feet, and each furnished with five beds, of which not more than four are generally occupied at one time. The ventilation in winter is obtained by the escape of the cold and foul air through an old-fashioned fireplace, in which a jet of gas is kept constantly burning, and by the free admission of pure air, which has been heated in the basement by passing around steam-chests, with large radiating surfaces. In summer, the admission of pure air depends exclusively upon open doors and windows, and the ventilation is, consequently, less perfect than in winter. In the spring and autumn months, there are many days in which the temperature is too warm for the free admission of heated air, and yet too cold for open windows. These are, therefore, the two seasons of the year which I dread the most, and in which I avoid, as much as possible, crowding the wards.

The wards are used invariably in rotation. By close management, and by crowding walking patients together, one of these wards in its turn stands idle for two or three weeks. During this time the doors and windows are kept open. Before it is again occupied by patients, the walls, floor, wood-work, and furniture—all of which are painted—are thoroughly scrubbed with carbolic acid soap, and then mopped over with a solution of half a pint of carbolic acid (Calvert's No. 4), to one pail of water. From this time until the ward is again vacated, no portion of it, not even the floor, unless accidentally soiled, is touched with water.

The nurses wear such clothing only as can be washed. As soon as the inmates of a ward are well enough to take care of themselves or of one another, their nurse is relieved from duty. She now takes a soap bath, puts on an entirely clean suit of clothes, and goes into a ward which has been thoroughly ventilated and cleansed. Before a new batch of patients falls to her care, she has had one week or more of rest. I visit the wards thrice daily, beginning always with the ward last occupied, and with the patient last delivered. Whenever a vaginal examination is needed, it is put off until all the other patients have been seen. The examining finger is then anointed with an ointment containing carbolic acid, and the hands are afterwards washed with carbolic acid soap. Post-mortem examinations I never perform. Whenever one is needed, an expert is called in, and remunerated for his services.

The beds consist of a tick filled with fresh straw and covered with an army blanket. After the discharge of a patient, her bed is emptied, and the tick, blanket, and bedclothes are boiled in water to which a little carbolic acid has been added. Each bed is furnished with a feather bolster and pillow, which are exposed on slats to the air when not in use. Once a year every bolster and pillow-tick in the house is washed, and the feathers baked and "renovated," as it is technically termed. They also pass through the same process whenever soiled, or whenever used by a patient whose convalescence has been delayed.

The patients come chiefly from the poorest classes; but many in more comfortable circumstances, with the hope of getting better care, seek admission on account of some difficulty attending their former labors. On this account, the proportion of difficult labors is much above the average. Those patients who have families often put off coming in until labor has actually begun, and then leave at the earliest possible moment. Notwithstanding this, since patients have the privilege of remaining four weeks after their delivery, the average stay of each one is sixteen days before delivery, and eighteen days after. Every patient, upon admission, takes a warm bath, and at least one a week thereafter before her delivery. If she exhibits signs of feeble health, she is at once put upon the use of quinia, and of the house mixture, consisting of two parts of the muriated tincture of iron, with three of dilute phosphoric acid. The habitual constipation of pregnancy is met by the administration, either in the morning of a teaspoonful of pulv. glycyrrhizæ comp. of the Prussian Pharmacopœia; or, at bedtime, of four Lady Webster's pills (pil. stomachicæ). When a more active purge is needed, the pulv. jalapæ comp. or the pil. cathartic. comp. (U. S. P.) is given. Headache and sleeplessness are treated by warm baths, by full doses of potassic bromide, and by the above-named medicines, when indicated; albuminuria is dealt with in pretty much the same way, but always with iron and phosphoric acid. The regular diet is plain and wholesome, yet more liberal than is usual in charitable institutions. Apart from the frequent use of aperients, a relaxed condition of the bowels is promoted by serving table-syrups at every meal, by fruits—fresh or dried, according to the season—and by all such vegetables as can be eaten raw, viz., lettuce, cress, radishes, leeks, onions, tomatoes, cucumbers, and cabbages. Of these, in this latitude, an ample supply is obtainable during nine months of the year.

When a patient falls into labor, she first has her bowels moved by an injection, and then takes a warm bath. The bag of waters is usually ruptured artificially, and the liquor amnii collected in a grocer's scoop. The second stage of labor is never allowed to linger; any delay is met by the use either of the vectis or of the forceps. As soon as possible after the birth and the removal of the child, the placenta is delivered by Credé's method. I may here remark that the still pulsating cord is first cut, then "stripped" of its blood, and as much as possible of its gelatin, and finally tied, when it has ceased to bleed and has become flaccid. Neither belly-band nor any kind of dressing is after-

wards applied, but the cord freely dangles about from the navel. Treated in this manner, it dries up without any bad smell, and falls off like a ripe fruit, without leaving a raw stump. Out of more than five hundred infants treated thus, not one has had a pouting or sore navel requiring treatment, and not one has had an umbilical hernia. I am also well satisfied that, by dispensing with the belly-band, I have had fewer cases of inguinal hernia. Those of my readers who wish a more detailed account of this method of dealing with the cord, can consult the *American Journal of Obstetrics*, vol. iii. p. 327.

Ergot is hardly ever resorted to as an oxytocic; but one teaspoonful of the fluid extract is invariably given as soon as the head presses upon the perineum. When the labor is over, the perineum is examined, and, if torn, is at once sewed up with silver sutures. The patient is now washed clean, and a binder and cylindrical compress applied, the latter in the hollow just beyond the fundus of the womb. The bedstead on which she has been delivered is next wheeled from the delivery-room to a ward and placed along the side of a bed, to which the woman now hitches herself over. Contrary to the generally held opinion that absolute rest after labor is indispensable, in no single instance has this muscular exertion apparently brought about a flooding. It seems rather to condense still further the uterine globe. Very rarely, indeed, has a flooding happened outside of the delivery-room. However warm the weather, a blanket is thrown over the patient, and a foot-warmer put to her feet. These remain until reaction sets in and she asks to have them removed. A mug of beef-tea made from Liebig's extract is now given, and the child put to the breast as soon as it will take it. Thereafter, in a natural convalescence, the woman gets tea, boiled eggs, bread and butter, for breakfast; potatoes, and some kind of meat, for dinner; stewed or fresh fruits, tea, bread and butter, for supper. On the morning following the day of her labor, the binder is removed for good, and she slips into a chair while her bed is making. This is repeated once or twice a day until the fourth or fifth day, when she, if so disposed, gets up and dresses herself. No patient quits her bed against her will; yet the force of example is so great that very few care to stay in bed, when they see their companions up and about.

No woman is allowed to suffer from after-pains. Whenever these are complained of, one-quarter grain doses of morphia are administered every hour until relief is obtained. In stubborn cases of after-pains I have found nothing act so promptly as the exhibition of ten grains of quinia every six hours, until the ears ring. For this valuable suggestion I am indebted to my friend Dr. Fordyce Barker. Bed-pans are not employed, except in cases of illness, or in cases requiring vaginal injections; but each woman has her own chamber-pot, which she uses indifferently, either in the sitting or the knee-elbow posture. Every woman is required to wash her own person at least once a day, and that with carbolic acid soap and a wad of fine oakum, which is at once thrown away. Only under very exceptional circumstances does the nurse cleanse the patient. Should the lochia become offensive, the woman is made to get out of bed and slip into a chair three or four times a day. This usually corrects the fetor; but if it does not, then and only then is a solution of potassic permanganate thrown up into the vagina. Firmly believing the nozzle of a syringe to be the medium of virus communication from patient to patient, I avoid the use of vaginal injections as much as possible. For a like reason, the temperature thermometer is not habitually used, but only in single cases as an aid to diagnosis.

Whenever the lochia are offensive, or the pulse is over 90, or the thermometer indicates a temperature higher than natural, or pelvic pains are complained of, or, in short, whenever any untoward symptom appears, quinia is given in from six- to ten-grain doses every four hours, until the ears ring. In addition, for abdominal pains large doses of morphia are given, and the whole belly is painted with iodine, and covered with a mush-poultice. The canonical purge on the third day is dispensed with. A patient has usually a movement of the bowels either before or on the day in which she gets up for good. If this does not happen, she takes four Lady Webster's pills at bedtime, which then act on the morning of the sixth day. As soon after getting up as she feels strong enough, she takes a warm bath.

Thus far I have stated the means adopted at the Preston Retreat for the prevention and the treatment of puerperal diseases. I now propose to give my reasons for such of them as need some explanation.

But few words are needed to explain why the ordinary chamber-pots are used, and why patients are made, once or twice a day after the first, to get out of bed and slip into a chair. The presence of putrescent fluids in the utero-vaginal tract is recognized by all writers as the great cause of the autogenetic variety of puerperal disorders. But the recumbent posture of itself necessarily tends to detain these poisonous discharges in contact with the traumatic lesions of labor. These discharges may also be partly imprisoned in the vagina through the swollen condition of the more external soft parts, or partly corked up in the uterine cavity by the presence in the cervical canal of a putrid clot. In such cases detergent vaginal injections are highly recommended. But clinically they will be found of limited value; for they cannot reach high enough, and do not ordinarily dislodge a large clot even when situated low down. True, intra-uterine injections are not open to one of these objections; but, apart from their being attended at best with some degree of hazard to the patient, the operation is too delicate a one to be intrusted to a nurse. Besides, in hospital practice the nozzle of a syringe—to say nothing of the fingers of a nurse—is, I fear, so often one of the vehicles for the transmission of virus, as to make this means of disinfection of doubtful propriety. In a local outbreak of fever, especially of the diphtheritic form, I should, however, suggest the use, immediately after labor, of vaginal injections containing the nitrate of silver or the persulphate of iron, in quantities large enough to sear over the traumatic lesions of labor. Such injections I have had no occasion to try, but they ought to inhibit active absorption and promote healthy granulation.

While seeking a substitute for the syringe, my attention was directed to the fact that the act of sitting on the ordinary chamber-pot often forced out putrid shreds or fetid clots, which had not been washed away by vaginal injections. This led me to discard, except in cases of positive illness, the use of bed-pans or of any other utensil—such as urinals—which can be used by a woman when lying on her back. Shortly after making this change, I found that, for like reasons, some shrewd and very practical writers of the last and the present century urged an early departure from the recumbent posture. Further: a residence of some years in the East had taught me that Oriental women, at least, can with impunity get up and be about a few hours after delivery. Influenced by these facts, I decided, cautiously at first, to introduce into the wards of the Retreat a system of puerperal gymnastics, consisting in no restraint whatever as regards the position in bed, and in the daily release from an irksome confinement. I was much pleased to find that the muscular exertion needed for these movements, so far from inducing hemorrhage, excited the womb to contraction, and emptied it and the vagina of their putrid contents. I

can testify that whenever the lochia are offensive, these upright positions, repeated several times a day, are excellent deodorants, better in fact than any detergent vaginal injections. There is yet another advantage gained by this plan: it affords, in hospital practice, an excellent opportunity for bundling the bed and bedding out of the ward and giving them a much-needed airing. In a crowded hospital-ward the hygienic importance of such repeated disinfection can hardly be overestimated. At the risk of being called an enthusiast, I will go a step further, and hazard the assertion that here is a form of puerperal septicæmia not necessarily accompanied by putrid lochia,—at least not appreciably so,—but indicated by high temperature, rapid pulse, complete anorexia, heavy sweats, and, later, by herpes labialis, which stubbornly resists treatment until the patient is made to get out of bed. This I have seen often enough, after keeping a woman on her back for some pelvic disturbance, to prevent any mistake as to the relation of cause and effect.

Lying-in women are encouraged to get up for good when they feel so disposed, because there are, to my mind, strong objections to the rigorous maintenance of the recumbent posture. Labor is, in general, a strictly physiological process, and there can be no sound reason why it should be made to wear the livery of disease. Nature teaches this very plainly, for most women wish to get up long before their physicians are willing to let them. The fact of a woman's wishing to get up is to me a very good reason why she should get up. In the second place, few physicians will deny that nothing so relaxes the tone of muscular fibre as a close confinement in bed. In my experience a woman ordinarily feels stronger on the fifth day than she does on the ninth, if rigorously kept under quilts and blankets. Once more: the upright position not only excites the womb to contract, but, by distributing the blood and equalizing the circulation, it actually lessens the amount of the lochia and shortens their duration. On the other hand, the dorsal decubitus keeps up a passive congestion of the womb as a whole, the engorgement of the greatly hypertrophied placental site, and a blood-stasis in the now thickened posterior wall,—all important factors in hindering the process of involution. Again: uterine diseases are hardly known among those nations whose women early leave their beds. From passages in the writings of the classics, it is evident that among the ancient Greeks and Romans, those models of physical strength and beauty, the women arose and even bathed in a running stream very shortly after delivery; in some cases, on the very day. Finally: what is sounder than all theory, a sufficiently long and well-sifted experience has proved to me that, by such a treatment, convalescence is rendered far more prompt and sure. At this result, very unexpected to the multiparous patients of the Retreat, they are constantly expressing their surprise.

The arguments against the customary purge on the second or the third day are to my mind very sound. I am well satisfied that the "milk-fever," for which it was originally introduced into practice, is essentially a myth. Genuine "milk-fever," as such, is a rare complication, and, when present, of no significance whatever. Unless the nipples are chapped or abraded, the engorgement of the breasts hardly ever leads to abscesses. In proof of this assertion, how rarely does mastitis follow still-births! In the vast majority of cases, the occasional constitutional disturbance, the chill-and-fever on the third or fourth day—the so-called "milk-fever"—is owing to a septic cause, and not to a mammary one. True, the breasts are by this time swollen and painful, but it is a mere coincidence, and coincidence is here mistaken for causation. Purges are, therefore, not only wholly unnecessary, but they disturb the equilibrium, and, what is worse, promote the absorption of septic matter. Partly from increasing the activity of the absorbents, the hemorrhages of labor are very liable to be followed by blood-poisoning. Now, the same result may be logically predicated of a depletion in the shape of a purge. Were my readers to go over their cases of puerperal fever or of other puerperal diseases, I think that they will find some of them dating from the day on which a purge had begun to act. Is it not more than a mere coincidence that these diseases attack a woman usually on the third or the fourth day—viz., the day of or following the administration of the customary purge? Three instances of puerperal peritonitis, two of them ending in death, have come to my knowledge, which were referable as plainly as could be to purgation. In one, the lady was slowly but surely mending from the effects of a severe instrumental delivery. For some reason or other she took, in the third week, an ordinary dose of citrate of magnesia. This violently purged her, and at once brought on a fatal attack of fever. In the other two the patients could not have been doing better, until they got a dose of castor-oil, which was given for no other reason than that the authors of our text-books were haunted by the bugbear of "milk-fever." Did space permit, I should like to show that this opinion is not shared by myself alone; that cases of phlegmasia dolens have been traced to the effects of a purge, and that the use of aperients during an epidemic of puerperal fever has been strongly condemned.

Quinia is given without stint, because, apart from its well-known tonic and antiperiodic properties, it possesses others which make it, above all remedies, the one best suited for puerperal disorders. By lowering high temperature it retards the oxidation of tissue, and hinders the formation of fibrinous concretions. By shortening the excursions of uterine fibres in their alternate contractions and expansions, it lessens the diastolic engorgement of the womb, diminishes the calibre of uterine blood-vessels, and thereby tends to keep their protective coagula from becoming loose and soluble. By contracting the placental site it proportionally limits that area of absorption. By constringing the coats of the capillaries, and by its inhibitory power over the migration of colorless blood-corpuscles, it either arrests suppurative inflammation or restrains its violence. Finally, it seems to exert a positive curative action on the blood in cases of putrid or purulent absorption. Clinically, I have found nothing comparable to quinia as a prophylactic against puerperal disorders, as well as a remedy for them. But it must be given early, frequently, in large doses, and pushed to a high grade of cinchonism.

Ergot is a very untrustworthy oxytocic. One never can tell beforehand whether it will behave kindly, or run a muck. It is, therefore, no favorite with me. The vectis and the forceps, being under perfect control, are far better oxytocics; their aid is therefore often invoked, in order to save a woman's strength, and to avoid that laxness of uterine fibre following a long and weary labor. Ergot is, however, given as the head is about to emerge, in order to lessen the chances of a flooding or of unruly after-pains, and to aid the process of involution by condensing the uterine globe to its minimum size. For an analogous reason I feel persuaded that Credé's method of placental delivery provokes to a more complete involution. It certainly empties the womb of all clots, and squeezes it down to its smallest capacity.

The prolonged use of the binder is given up, for reasons which have been published in this journal (April, 1874, p. 8). I shall therefore not repeat them. I wish, however, here to state that even its brief use during the first few hours after labor is not held by me as a cardinal point. I begin to have grave doubts

whether it is of any value whatever in the prevention of hemorrhage. On the score of utterly abandoning it I am quite open to conviction.

So much for the reasons on which the foregoing measures are based. Let me now give the results. Up to date there have been 756 cases of delivery, with six deaths. The following are the order and the numbers of the fatal cases, as copied from the Case-Book:

"No. 22. Concealed accidental hemorrhage from the gravid womb. No. 203. Puerperal peritonitis. No. 289. Acute chorea. No. 360. Caries of petrous portion of the temporal bone. No. 398. Chronic pelvic abscess. No. 647. Septic pneumonia."

The case of puerperal peritonitis was an isolated one. The woman had been abandoned by her husband, to whom she was devotedly attached. She fretted and brooded over this desertion in so despairing a manner as to make me apprehensive of mania. Three other patients occupied the same ward with her, but they escaped from contagion.

Cases 22, 289, and 360 were deemed by me so exceptional that their histories were reported to the Obstetrical Society of Philadelphia, and afterwards embodied in its Transactions (*Am. Journal of Obstetrics*, vol. ii. p. 286; vol. iii. p. 140; vol. iv. p. 126). Case 398 was that of an old pelvic abscess following a previous labor —viz., an abortion produced by the kick of a drunken husband. During the last week of utero-gestation this abscess began to inflame and to cause her so much suffering that very large doses of morphia were needed to control it. Labor very greatly intensified this distress. When the womb was emptied a tumor was found in left broad ligament, and all the symptoms of localized peritonitis were present. Under appropriate treatment she soon began to mend; but on the fourteenth day she was suddenly seized with violent abdominal pain, and fell into a collapse, from which she never rallied. An autopsy, made by my friend the editor of this Journal, revealed an old pelvic abscess, which had burst into the cavity of the abdomen. This case, it seems to me, cannot fairly be attributed to a septic cause, but to the ante-partum recrudescence of an old lesion. Case 647 is one of doubt in my mind. There were no appreciable pelvic or abdominal lesions; and yet, in default of an autopsy, which was not permitted by her friends, I think it fairer to attribute the pneumonia to blood-poisoning rather than to a non-septic cause.

To sum up, then,—out of 756 cases of labor there have been 2 deaths from septic causes; 1 death from the bursting of an old abscess; 1 death from hemorrhage; 2 deaths from non-puerperal diseases.

Apart from the above record the Case-Book exhibits no case of phlegmasia dolens, and none of pelvic abscess. One woman, however, had, I am told, a pelvic abscess at home. Through fright at an outbreak of measles in the building, she insisted on rising from her bed and on being discharged on a wet winter night. Although a large proportion of the inmates were primiparæ, and two of them confirmed epileptics, but two cases of eclampsia took place, and these in women who had not been subjected to any prophylactic treatment. The one, while laboring under violent convulsive attacks, was brought in a hack by her friends. The other was seized the day after admission. Both recovered under repeated rectal injections of drachm doses of the hydrate of chloral, and a final delivery under ether with the forceps.

Since nothing is so fallacious as statistics, even when based on large averages, it is with much diffidence that I offer the above meagre data. They may not sustain my views; but they will, I hope, show that lying-in women can be gainfully treated in a manner less artificial than is customary, and more in accordance with the maxim *naturâ duce*.

One word more: For many reasons the statistics of a lying-in hospital can never compete with those of private practice. Of these I shall adduce but two. In the first place, the former are more trustworthy, for physicians very naturally shrink from reporting their fatal midwifery cases as such. I have known a death from post-partum hemorrhage returned as one from "anæmia," and another from puerperal albuminuria as a case of "pneumonia"—œdema of the lungs being present; whilst fatal cases of puerperal septicæmia are constantly being certified to under the heading of some prominent symptom which tells no tale, such as "peritonitis," "pleuritis," or "pneumonia." For instance, during a period of eight weeks of this year, I was asked to see eight cases of puerperal fever,—four of them from one Sunday to another. Of these all but one proved fatal. During the same time I casually became cognizant of seven other fatal cases. Now, during these eight weeks I studied with much interest the weekly returns of the Board of Health, and found there reported just twelve deaths from "puerperal fever." There were, however, also reported eleven deaths from "inflammation of the peritoneum," one death from "child-bed," and one each from "septicæmia" and "pyæmia." Comment on the above is unnecessary; the figures speak for themselves. In the second place, physicians naturally shirk the worry and anxiety, the delay and trouble incident to difficult labors in their private practice, especially when such occur in a class from which they can expect no adequate remuneration. A hospital thus becomes the Cave of Adullam for all these abandoned cases. For instance, out of the six fatal cases which I have reported from the Case-Book of the Retreat, the one of chorea and that of hemorrhage were sent to the institution by the family physician,—the former on account of her being unmanageable at home, the latter because her labors were growing more and more difficult from an exostosis. The two epileptics* adverted to, two distressing cases of phthisis and valvular disease of the heart, and many of difficult labor in multiparæ, come under the same category. There are at present in the building two women not yet delivered, who were sent there by their respective medical attendants. The one is an epileptic primipara; the other a secundipara with a vesico-vaginal fistula,—the result of craniotomy in her previous delivery. It is thus that the death-rates of lying-in hospitals show to disadvantage beside those of private practice.

GLEANINGS FROM OUR EXCHANGES.

MALARIAL PARAPLEGIA (*The Clinic*, October 3, 1874). —Dr. C. E. Beardsley reports four cases of paraplegia in children from three to five years of age, who were seen twenty-four hours after the first attack. All of them were females, healthy in appearance, well nourished and well clothed. None complained of pain. The temperature was nearly normal. Pulse regular, but a little accelerated. They were cheerful, with good appetite. No difficulty in micturition or defecation. The muscles of the upper extremities were perfect in all of their movements and obeyed the dictates of the will. There was anæsthesia of both lower extremities, with absolute paralysis of all the muscles. The above symptoms were developed suddenly without any known cause, but were accompanied by a piercing cry and loss of motion. One of the cases proved fatal. Spinal

* I am not aware that epilepsy predisposes to puerperal eclampsia—at least I have not found it to do so. But many physicians look upon it as a dangerous complication in labor.

congestion probably existed in all of them, and in two spinal hemorrhage occurred, malaria being the cause in all. The treatment consisted of first a saline purgative, followed by bromide of potassium for some hours with quinia; then quinia alone some hours; finally the galvano-faradic current.

EMULSIO CARNIS.—At a meeting of the Société d'Emulation pour la Science Pharmaceutique, M. Yvon proposed the following as an excellent form for the administration of raw meat:

℞ Raw meat, ℥viij;
Sweet almonds, ℥ijss;
Bitter almonds, ℥iss;
White sugar, ℥ijss.

The almonds are blanched, and the whole beaten together in a mortar until a rose-colored homogeneous paste is obtained. This is of an agreeable flavor, and may be mixed with water to form an emulsion, or it may be beaten up with the yolks of eggs, and mixed with milk instead of water.—*Detroit Review of Medicine and Pharmacy*, October, 1874.

Mr. James Kemble, in the *American Journal of Pharmacy* for October, proposes the following very similar formula:

℞ Fresh raw beef (lean), ℥vi;
Sweet almonds, deprived of their shells and roasted, ℥i;
Bitter almonds, ℥vi;
Sugar, ℥vi;
Glycerin, ℥ii;
Water sufficient for emulsion, ℈i.

Rub or beat the beef, almonds, and sugar to a fine pulp in a wedgwood or wooden mortar, then add water gradually until a smooth emulsion is formed, and strain through a sieve or coarse cloth; return the residuary mass to the mortar, manipulate with the balance of the water until f℥xiv are obtained, strain all through a finer strainer, add the glycerin, and bottle; the bottle is to be kept well corked. Dose, f℥i, containing ℥iii of the beef.

The physician, in prescribing, can order the addition of brandy, pepsin, or any other medicine he wishes to administer at the same time.

RATTLESNAKE-POISON (*The Southern Medical Record*, September, 1874).—Dr. S. M. Rivers relates several cases of snake-bite, in one of which death took place within three hours after the reception of the poison. He describes the effects of the poison as those of a narcotic sedative, consisting of an intense burning in the wound, extending over the body, even to the top of the head; vertigo, nausea and vomiting, dimness of vision, irregular spasmodic action of the muscles; then delirium, relaxation, depression of the vital powers, and death by syncope. The only reliable remedy is powerful alcoholic stimulation in conjunction with ligatures above the wound, and suction by means of cups or the mouth directly over it.

MISCELLANY.

FEMALE ARMY-SURGEONS.—The Vienna *Medicinisch-Chirurgische Centralblatt* reports that the Committee of the Society for the care of the Sick and Wounded in War in St. Petersburg has approved of a proposal for allowing women to perform the duties of military surgeons in the field and in stationary hospitals. To carry out the plan it is intended to institute courses of instruction for female army-surgeons (*Feldscheererinnen*) in the Russian universities.—*London Medical Record.*

SLOW PROGRESS OF HOMŒOPATHY IN GREAT BRITAIN.—The *Medical Press and Circular* notices a leading article in the *Homœopathic Review*, in which the latter laments over the unattractiveness of the homœopathic practice, and makes an appeal to its readers to unite in seducing, if possible, the rising generation of the medical profession. The *Review* makes the statement that "of the towns in England above 10,000 and below 20,000 population at the last census, 45 possessed no qualified representation of homœopathy at all, and twelve other towns had only one each; of the towns between 20,000 and 50,000 population, no less than 38 had no resident homœopathist,—14 of them had only one each, and 5 other only two each; of the towns between 50,000 and 100,000, 9 had no homœopathic physician, 7 had only one each, and six others had only two each; while there were, and are actually, 4 towns above the 100,000 limit in which no homœopathist has settled."

The *Review* further says, . . . "Neither can we feel satisfied that our hospitals and dispensaries do at all what they might do in the way of influencing third and fourth years' students. What has London done in this matter with its hospital of sixty beds? What has Birmingham with its well-tried staff and influential committee? What have the Liverpool dispensaries, which admit their 10,000 to 12,000 cases a year? Is it not from these places that our recruits have come, or are coming? . . . The local influence of these institutions on the members of the profession, and on the students in our metropolitan and provincial schools, is practically *nil*."—*The Medical Record.*

MEDICAL BOARD OF BELLEVUE HOSPITAL.—The following is the Medical Board of Bellevue Hospital as constituted by recent resolutions of the Commissioners of Public Charities and Correction:

Consulting Physicians and Surgeons.—John T. Metcalfe, B. W. McCready, William H. Van Buren, Isaac E. Taylor, Fordyce Barker, Lewis A. Sayre, Alexander B. Mott, and John J. Crane.

Visiting Physicians and Surgeons.—Austin Flint, Sr., James R. Wood, Alonzo Clark, Henry B. Sands, Alfred L. Loomis, Stephen Smith, Wm. B. Eagar, Ernst Krackowizer, Edward G. Janeway, Frank H. Hamilton, Francis Delafield, Thomas M. Markoe, William H. Thomson, Erskine Mason, Gouverneur M. Smith, and John W. S. Gouley.

OFFICIAL LIST

OF CHANGES OF STATIONS AND DUTIES OF OFFICERS OF THE MEDICAL DEPARTMENT U.S. ARMY, FROM OCTOBER 6 TO OCTOBER 12, 1874, INCLUSIVE.

HUNTINGTON, D. L., ASSISTANT-SURGEON.—Assigned to duty as Post-Surgeon at Angel Island, California. S. O. 101, Department of California, October 1, 1874.

PHILLIPS, H. J., ASSISTANT-SURGEON.—To report in person to the Commanding General, Military Division of the Atlantic, for assignment to duty. S. O. 218, A. G. O., October 7, 1874.

LORING, L. Y., ASSISTANT-SURGEON.—Assigned to duty at Camp Apache, A. T. S. O. 86, Department of Arizona, September 18, 1874.

CORSON, J. K., ASSISTANT-SURGEON.—Granted leave of absence for one month, provided he furnish a suitable substitute during his absence. S. O. 161, Department of the South, October 7, 1874.